Foods Your Child Ate In The Past 4 Weeks:

Please write in the number of times in a day, week or month that your child ate the following foods:

For example, during the past month if your child ate:

Cereal once a day, write a 1 in the Daily column after cereal.
Salad 4 times a week, write a 4 in the Weekly column.
Sweet potatoes twice a month, write a 2 in the Monthly column.
If your child doesn't eat the food listed, place a check (✓) in the Never column.

	Daily	Weekly	Monthly	Never
Cereal: Hot or cold	**1**			
Lettuce, green or red leaf, romaine		**4**		
Carrots, sweet potatoes, winter squash			**2**	
Pork, roast or chops, ham				✓

Bread and Cereal

	Daily	Weekly	Monthly	Never	
Whole grain (wheat or oat) bread, rolls, or bagels (indicate the number of slices eaten per day or week)					
White bread, rolls, bagels or buns (indicate the number of slices eaten per day or week)					
Muffins, waffles, pancakes, quick breads, biscuits					
Cereal: hot or cold					
Pasta (spaghetti, macaroni, noodles)					
Rice, barley, bulgur					(84)
Crackers, pretzels, popcorn					Std. 42
Staff use only					
	x 7 =		**÷ 4 =**		

Fruit and Fruit Juice

	Daily	Weekly	Monthly	Never	
100% juice with Vitamin C or juice you get from WIC orange, apple or grape. How many ounces does your child drink at a time? _____ounces					(89) 1-5 yr=4 oz
Oranges, grapefruit, strawberries					
Cantaloupe, watermelon					
Apples, bananas, grapes, pears, applesauce, canned fruit					(86)
Raisins, dried apricots, prunes					Std. 14
Staff use only					
	x 7 =		÷ 4 =		

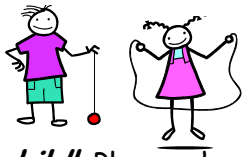
Vegetables	Daily	Weekly	Monthly	Never	
Carrots, sweet potatoes, winter squash					
Broccoli, spinach, beet greens, swiss chard					
Tomatoes, tomato sauce, red or green peppers					
Potatoes, baked, boiled, roasted or salad					
Corn, peas, green beans, beets					
Lettuce, green or red leaf, romaine					(83)
Soup: vegetable or tomato					Std. 21
Staff use only					
	x 7 =		÷ 4 =		

Meat, Poultry, Fish and Beans	Daily	Weekly	Monthly	Never	
Peanut butter, nuts					
Baked beans, pinto or kidney beans, lentils					
Hamburger (prepared in any way)					
Chicken or turkey					
Hot dogs, cold cuts, sausage or bacon					
Tofu, tempeh, hummus					
Fish, fish sticks, canned tuna					
Steak or roast (beef, venison)					
Pork, roast or chops, ham					(82)
Eggs					Std. 14
Staff use only					
	x 7 =		÷ 4 =		

Milk and Cheese	Daily	Weekly	Monthly	Never	
Milk, type : (Circle) skim, 1%, 2%, whole How many ounces does your child drink at a time? _____oz.					1-3 yr=4 oz 4-5 yr=6 oz
Yogurt					
Ice cream, pudding or cottage cheese					
Hard cheese: American, cheddar					(81)
Meals with Cheese: pizza, macaroni and cheese					Std. 21
Staff use only					
	x 7 =		÷ 4 =		

Other	Daily	Weekly	Monthly	Never
Formula				
Cookies, cake, brownies, pie, candy				
Chips (potato, corn, other), french fries				
Soda, Kool-aid, Hi-C, Tang, Sunny Delight				
Water				

Health and Nutrition Screening Form
Children 1-5



Child's Name: _____

Age: _____

We want to know about your ***wonderful child!*** Please share with us answers to the questions on the next few pages. The answers to these questions will be kept confidential.

Check (√) the answer or fill in the blank.

	Staff use only
1. Was your child ever breastfed? ____Yes ____No ____Still breastfeeding If yes, how long was your child breastfed? ____Number of weeks (Answer only if child is less than 2 ½ years)	
2. Does your child have any food allergies? ____Yes ____No If yes, which foods?	40
3. How many times a day does your child eat? (Include meals and snacks) ____1-2 ____3-4 ____5-6 How many meals does your child eat away from home? _____ per day **or** _____ per week	
4. Does your child take a bottle to sleep? ____Yes ____No If yes, what is usually in it?	87
5. Has your child been to a dentist in the past 12 months? ____Yes ____No	
6. Has your child been hospitalized or had surgery during the last 6 months? ____Yes ____No	39
7. Does your child take any of the following? Vitamins ___ no ___yes _____ _____ Iron ___no ___yes _____ _____ Fluoride ___no ___yes _____ _____ Medication ___no ___yes _____ _____ (If yes, What kind? / How often?)	38
8. About how many hours did your child sit and watch television or videos yesterday? ☐ none ☐ <1 hour ☐ 1 hour ☐ 2 hours ☐ 3 hours ☐ 4 hours ☐ 5+ hours	
9. Is your child in a home with someone who smokes? ____Yes ____No If yes, ☐ 3 days per week or less ☐ person only smokes outside ☐ 4 days per week or more ☐ occasionally	
10. Were there any days last month when your family didn't have enough food to eat or enough money to buy food? _____ Yes _____ No Would you like information on food resources in the area? _____ Yes _____ No	
11. What questions do you have about feeding your child?	

Date assessed:

24 Hour Intake (Staff use only)